JUSTICE CABINET **DEPARTMENT OF** **JUVENILE JUSTICE** **POLICY AND PROCEDURES**	**REFERENCES:** **3-JTS-4C-47** **3-JDF-4C-45** **3-JCRF-4C-27** **1-JDTP-3B-19** **1-JBC-4C-42, 43** **1-SJD-4C-27** **NCCHC Y-10, 11**
CHAPTER: Administration	**AUTHORITY: KRS 15A.065**
SUBJECT: Death of a Youth	
POLICY NUMBER: DJJ 147	
TOTAL PAGES: 4	
DATE ISSUED: 08/01/02	**EFFECTIVE DATE: 08/15/02**
APPROVAL: Ralph E. Kelly, Ed.D.	**, COMMISSIONER**

I. POLICY

In the event of the death of a youth in an out-of-home placement prompt notification shall be provided to the coroner and appropriate law enforcement officials, to the parent or guardian of the youth, and to Department of Juvenile Justice officials. An Internal Review Process shall be established by the Commissioner to review all fatalities of youth in out-of-home placement.

II. APPLICABILITY

This policy shall be applicable to all youth under the care and custody of the Department of Juvenile Justice.

III. DEFINITION

Not Applicable

IV. PROCEDURES

A. Notification to the parent shall be made by the Juvenile Service Worker except in the case of detention, alternative to detention and day treatment programs where the Superintendent or Detention Alternatives Coordinator shall be responsible for notification.

B. Staff shall follow these procedures when death occurs in a youth development center, DJJ operated or contract day treatment center or group home; or DJJ operated detention center:

1. Staff on duty shall immediately notify the Emergency Medical Services (EMS), the Superintendent or ADO and the program nurse, where

applicable, of the death of the youth. The EMS location and phone number shall be posted by the telephone in each program.

2. Staff on duty shall not disturb the body or the immediate area beyond any action necessary to check for vital signs or provide emergency resuscitation techniques.
3. The Superintendent or ADO shall notify the local law enforcement officials immediately upon the death of a youth.
4. The Superintendent or ADO shall immediately notify the Regional Facilities Administrator or Regional Manager and the Juvenile Service Worker. The Juvenile Service Worker shall immediately notify the parents or closest relative. Reference DJJPP 411. The Deputy Commissioner of Operations and Commissioner shall be notified immediately (not to exceed 24 hours) through the normal chain of command.
5. The Superintendent or ADO shall, without disrupting the scene or evidence, immediately investigate the incident, keeping in mind that if abuse, neglect, or exploitation is suspected, Child Fatality Investigations shall apply. In addition, the Superintendent shall immediately report any alleged abuse or neglect to the Internal Investigations Unit.
6. In the event the death of a youth occurs off campus and out of staff supervision (i.e., AWOL, home, furlough, off-campus work site, school, etc.), the same notification and documentation procedures shall apply. The Superintendent or ADO shall cooperate and communicate with the person in charge at the location of the death. Documentation, in addition to that required in these procedures, shall cover the circumstances surrounding the youth being off campus and out of staff supervision.
7. In compliance with KRS 72.020, the local Coroner's office shall be notified immediately.
8. All inquiries from the press shall be referred to the Public Information Officer.
9. Detailed documentation of the incident shall be entered in the case record by staff as soon as possible, including the time the Coroner was notified and pronouncement of death given, names of all staff involved, and all subsequent notifications of parents and guardians. All pertinent notifications and significant facts related to the death shall be fully documented in the client file. All staff with direct information regarding events surrounding the death shall document this information on an Incident Report.

10. A final written report shall be prepared by the Superintendent to be submitted to the Regional Facilities Administrator or Branch Manager and the Division Director, with copies to the Deputy Commissioner for Operations and the Commissioner. Along with this report, a copy of the Coroner's or Doctor's report, and autopsy report when applicable, and any other relevant documentation shall be attached or forwarded to the Regional Director upon receipt.
11. The youth's record shall be maintained at the facility until a final Coroner's report is entered into the record.
12. Under Kentucky law, autopsies may be authorized by the Coroner, next of kin, or court order on petition of the County or Commonwealth Attorney. Staff may not authorize autopsies except in unusual circumstances, and then only upon advice of the Department's General Counsel and with approval of the Commissioner.

C. Staff shall follow these procedures when death occurs in the community or a community-based program:

1. The Juvenile Service Worker shall immediately notify the Juvenile Service District Supervisor, Regional Manager and local law enforcement officials upon the death of a DJJ youth in a:
    a. Foster Home;
    b. Private Child Care Facility;
    c. Psychiatric Hospital; or
    d. Non-DJJ operated Detention Facility.
2. The Division Director, Deputy Commissioner of Operations and Commissioner shall be notified immediately (not to exceed 24 hours) through the normal chain of command.
3. The Detention Alternatives Coordinator (DAC) shall immediately notify local law enforcement officials and their supervisor, who shall upline according to the chain of command, upon the death of a youth in an Alternative to Detention Program.
4. Notification to law enforcement shall include both County of Origin and County of Placement, if different.
5. The responsible Juvenile Service District Supervisor shall designate staff to determine whether neglect or abuse is suspected in those situations where other youths are in the same placement. If the designated staff finds

that neglect or abuse is involved, procedures outlined in DJJ Policy 140 shall be followed.

6. Procedures IV. A.7, 8, 9 of this policy shall be followed.
7. Service providers having direct knowledge of the events surrounding the death shall be requested by the Juvenile Services Worker to supply a written narrative regarding the death for inclusion in the client file.
8. The Regional Manager shall submit a final written report to the Division Director, with copies to the Deputy Commissioner of Operations and the Commissioner. Along with this report, a copy of the Coroner or Doctor's report, and autopsy report when applicable, and any other relevant documentation shall be attached or forwarded to the Division Director upon receipt.

D. The Internal Affairs Unit (IAU) shall be contacted within five (5) working days of the fatality to conduct a fact-finding investigation of the incident. Written report of the investigation shall be submitted through the Deputy Commissioner(s) to the Commissioner.

E. The IAU shall review policy and procedures applicable to the incident, conduct staff and youth interviews, and review all documentation of the incident to determine if existing policy and procedures were appropriately implemented. The IAU shall submit its report to the Commissioner within thirty (30) calendar days of the date of the fatality. (This timeframe may be extended by the Commissioner in the event that the Coroner's report is not finalized.)

F. If a plan of corrective action is recommended by the Commissioner, the Division Director shall submit a subsequent report regarding the implementation and results of the corrective action to the Commissioner within thirty (30) calendar days of receiving the report. Follow-up reports may be requested at the Commissioner's discretion.

G. All family and personal resources shall be exhausted prior to recommending expenditure of Departmental funds for funeral and burial expenditures.

V. MONITORING MECHANISM

Monitoring shall be done by the Deputy Commissioners.